Best Practices in the Acquisition and Use of Independent Medical Evaluations:

A Synthesis of Recommended Practices from
A Review of Pertinent Literature
And Interviews with Executives at Selected Organizations

Compared to

Current Practices
At the Washington State Department of Labor & Industries

Chapter 3

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Med Fx, LLC
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I. Synthesis of Recorded Best Practices from the Literature and Selected Organizations

This section states the best practices we found in our research activities, grouped by a number of topic areas.

Rates of IME Use

Estimated Rates of IMEs

The rate of IME use is an important indicator of system performance because IMEs are expensive and they tend to create an adversarial atmosphere or exacerbate one that exists if expectations are not managed correctly.

The most appropriate way to calculate the rate of IMEs is the number per average inventory of open lost time claims per year. Few participants in the comparison exercise have data on the number of claims in their inventory, or the number of IMEs obtained per year. State regulators are aware of the approximate number of IMEs ordered for dispute resolution. We therefore asked participants the rates of IMEs per 100 lost time claims in their claim inventory to understand the range of resource use. In general, rates of use are quite low among national carriers and self-insured employers. They are somewhat higher among TPAs and higher among state funds. These rates are much higher, by an order of magnitude, in Washington than anywhere else. The rate of IMEs in Washington approaches 15% of the annual inventory of claims. Part of the difference is attributable to statutory requirements. For example, in California, Attending Physicians are required to provide some of the data typically obtained through an IME in Washington. Despite these differences, there remains a substantially higher rate of use of IMEs in Washington.

By contrast, estimated IME rates are reportedly quite low in Kentucky, Wisconsin, Indiana, and Connecticut. The medico-legal atmosphere in these states is viewed as

significantly less fractious than in Washington, due in part to the agreement on the part of the medical and legal communities to work together in a non-adversarial manner. Oregon and Kentucky have high penetrations of MCOs (Managed Care Organizations). MCOs are required by statute or regulation to have multi-tiered internal dispute resolution mechanisms similar to those required for HMOs, so the disputes about medical issues rarely reach the litigation stage. Interestingly, California, which has the reputation of having a high litigation rate, did not have a particularly high rate of Qualified or Agreed Medical Examinations. This is largely a result of Attending Physicians performing most exams and the fact that actual litigation rates are lower than reputed.

Alternative Dispute Resolution

Wisconsin, North Dakota and Virginia use peer-review based resolution of medical fee and utilization disputes, using groups of peer physicians to decide the issue. Texas uses hearing officers. Alabama uses medical experts to assist the Department of Industrial Relations' ombudsman in resolving medical disputes. Rhode Island's Medical Advisory Board and Tennessee's Medical Care and Cost Containment Committee may be used to resolve disputes there.

Limits on the Rates of IMEs

An accurate determination of the limits placed on the use of IMEs is complicated by indistinct terminology. Some states allow for employer's examinations in addition to IMEs, and others provide both for independent and impartial medical examinations. Generally, the IMEs must be ordered at "reasonable" intervals (most commonly no more often than every 6 months) or for "reasonable" cause, for example to resolve a medical dispute or because of a change in condition. West Virginia and Ohio are exceptions, in that they provide for IMEs to be performed on a regularly scheduled basis. Louisiana and Virginia prohibit more than one exam by examiners of the same specialty without authorization.

Requirements and Reasons for IME Requests

Legal and Regulatory Requirements

Each state has legal and regulatory provisions governing the collection and use of medical information, the circumstances under which IMEs may be obtained, and the qualifications and selection process for examiners. Many statutes and regulations are silent in one or more of these areas. Most states allow the Workers' Compensation Board to order a physical examination of a claimant by a physician of its choice, and allow insurers or employers to order a physical examination of a claimant by a physician of their choice.

Some states allow IMEs at the discretion of the employer/insurer or "as needed" (for example, Alaska). The majority of states allow IMEs to resolve disputes, especially regarding treatment, nature of injury, and disability (for example, Arizona). Some states use IMEs mostly for permanent partial disability ratings (for example, Iowa). Some states require a hearing before the Board can order an IME (for example, Hawaii). As discussed previously, Washington's statutory environment is reasonably permissive and the use of IMEs has developed as part of a set of institutional practices.

Uses of IMEs

According to the literature reviewed, claims adjusters may use IMEs to provide guidance about entitlement issues such as the work-relatedness of a medical condition, the need for further medical or income benefits, and the nature and extent of permanent impairments.

IMEs may be used to guide management of medical care, disability, and rehabilitation when the claims adjuster is concerned that the care may be inadequate, inappropriate, or that return to work is unreasonably delayed. Case managers (adjusters, nurses, and

medical directors or consultants) and rehabilitation specialists may need clarification of the diagnosis, appropriateness of treatment, or need for work modifications or absence when required information has not been made available by other means, or when the claims adjuster believes the existing information to be inaccurate.

IMEs can be a source of expert medical opinions on issues of diagnosis, causality, treatment or impairment for defense or claimants' attorneys and workers' compensation commissioners or judges. Attorneys, adjusters, and judges generally seek information to clarify a disputed point. In many states, the IME itself is not admissible evidence; the testimony of the examiner is considered the evidence, whereas the report is hearsay unless both parties agree to the contrary, or the administrative law judge accepts the report in evidence (for example in Kentucky).

There is a general consensus that IMEs are not the preferred method for obtaining basic medical information for claim and case management, but can be an invaluable aid when the health problem is unusual, causality is unclear, or the nature or need for the proposed treatment is controversial. Careful histories done as part of IMEs may also be used to elicit hitherto unknown facts in a situation or to uncover reasons for delayed functional recovery.

Issues by Phase of Claim

The best practice for obtaining and using IMEs depends on the area of inquiry, which in turn is linked to the phase of the claim. At inception, appropriate issues to evaluate include causality and diagnosis. During the course of the claim, IMEs are appropriately used to evaluate testing and treatment appropriateness or disability management. At closure, IMEs are appropriate to obtain an opinion of MMI ("maximal medical improvement"), an assessment of impairment rating, or prediction of future medical needs if the information is not available from the attending physician, is felt to be biased or inaccurate, or is needed to resolve a dispute.

Claim Inception

Diagnosis

In general, benchmarking participants feel that it is not necessary to obtain an IME to confirm diagnoses in a new claim, unless fraud or malingering is suspected. IMEs are sometimes obtained if the treating physician records an unusual or serious diagnosis. Participants said that before obtaining an IME, their adjusters or nurses review printed materials or do a literature search in order to understand the diagnosis better and match the facts of the case to the published criteria, mechanism, symptoms and signs for it. The claims team also consults available clinical practice guidelines to determine if there is a match, or asks the medical director for a review of the records. If the situation is still unclear, then an IME with a hands-on assessment might be appropriate.

Causation

Participants offered a number of strategies to analyze causation short of an IME. Most participants suggest obtaining all available medical information such as old records of medical and job exposure, and comparing the signs and symptoms to the route, dose and duration of exposure for diseases. Internal reviewers then correlate the exposure history with the known epidemiology of the disorder claimed to be present. One must have an accurate diagnosis to correlate the entity present with studies linking it to occupational exposures. Previous complaints of a similar problem are sought for traumatic or cumulative injuries. One national insurer routinely deposes workers whose health problems do not appear to be work-related in order to have the history taken for the record. If these methods fail, then an IME is secured.

Some carriers and the State of Kentucky automatically order an IME for occupational diseases, hearing loss, and psychiatric disorders. In Kentucky, specialists at University

centers carry out these evaluations.

During the Claim

Delayed Functional Recovery

Delayed functional recovery refers to the deviation of the claimant's recovery of function from expected time-based norms. The best practice in using IMEs to manage delayed recovery is contingent on the availability of information and the time in which it is available. The preferred practice is to obtain the information directly from the Attending Physician. If not otherwise available, the best practice is to obtain an IME as soon as time-based benchmarks for return to function for the given diagnosis and treatment program are exceeded. Several national carriers obtain an IME at 4 weeks if it is unclear why a claimant is not back at work. The Ohio State Fund has an automatic trigger for an IME at 90 days for the same reason. Neither practice apparently results in a large number of IMEs, but the former in particular does keep the focus on functional recovery by quickly ascertaining why the claimant is off work and calling for intensive case management as appropriate.

Prolonged Treatment

Prolonged treatment refers to courses of treatment that exceed the recommended duration of care in evidence-based guidelines. The best practice in this area is to obtain an IME promptly after the recommended duration of care in those evidence-based guidelines has been exceeded if the reasons that this case is different are not available elsewhere. Many payers obtain IMEs if there is prolonged or apparently ineffective treatment. While there were no specific time frames given, practice guidelines for soft tissue complaints would indicate a four to six week time frame if the report from the attending physician does not contain a workup for undetected problems, complications, and risks for delayed functional recovery, and a clear explanation for continued treatment.

At Claim Closure

MMI

If the claimant appears to be at maximal medical improvement, but the attending physician does not agree, an IME may be appropriate. Again, the clear preference was to obtain information about MMI from the attending physician. Most carriers have form letters requesting this information. The key ingredient for successfully addressing this issue is seeking the information promptly when medians for treatment duration or other norms indicate that the average course of treatment should have concluded.

Impairment Assessment and Rating

Most states require an impairment assessment or rating at the conclusion of the claim if the attending physician (AP) states that the claimant has not recovered to his or her pre-injury status. The preference is to ask the AP if the claimant has regained his or her former health status, and if not, obtain information needed for rating from the AP. There is a treating physician presumption (official or unofficial) in most states, making the attending physician the preferred initial source of information.

The best practice is to obtain an IME only if the attending physician declines to evaluate or rate the patient. Not all states require that the attending physician perform the rating calculations. In California, for example, the attending physician is required to complete a detailed report that includes a listing and review of medical records, a longitudinal history of the health problem, a focused but detailed physical examination, a summary of subjective and objective factors of impairment, a discussion of needs for rehabilitation, analysis of the case, and a projection of future medical needs. Specially trained Department of Workers' Compensation staff members assign the rating itself.

If an attending physician description is unclear or inadequate or the rating appears to be inaccurate, the recommended next step is to ask for specific clarification. If that fails, then the claims team can get an IME. It is common practice for claim managers to review reports from "known" low or high raters. Again, this knowledge is anecdotal. No one in the comparison group has a database tabulating expert recomputation of ratings or IME assessments.

Alternate Means of Information Gathering

In the benchmarking interviews, IMEs are seen as a last resort in obtaining information. The act of sending a claimant to an external evaluation is itself perceived as confrontational and adversarial by the claimant. It does not appear to be a best practice to incur the cost, time, and potential ill-will of an IME in many cases given that interviewees report that only 1-3% of lost time cases reach the judicial level. Further, the evaluation and its results are not usually obtained soon enough to effectively manage care.

The preferred order for obtaining medical information is to first ask the attending physician, to obtain an internal file review if that does not succeed, next to obtain a consultation, and only as a last resort to get an IME. There are exceptions. For example, if there is a complex or unusual exposure with which the attending physician is unfamiliar, a referral to a specialist initially might be warranted to establish causation in accordance with current scientific evidence.

Some respondents feel that in some cases, a "preemptive IME" is a best practice to avoid accepting responsibility for cases with potentially questionable work-relatedness, or to provide a baseline for medical and disability management in cases where the provider has a history of prolonged and perhaps less than effective treatment. Situations mentioned where preemptive IMEs are used include claims for occupational disease, reopening of cases, particularly to validate causation, or a prior history of prolonged treatment.

Preemptive IMEs are also felt to be appropriate if the treating physician is "known" not to communicate or has "known" unusual practices. We should note that no one we spoke with had a database with this information in it; these histories were based on individual or institutional memory.

Frequency of Issues Addressed by IMEs

We were unable to locate any published studies of the distribution of reasons for obtaining IMEs. Further, no participants in the benchmarking study have such data for their company or jurisdiction. Since no quantitative data are available, we asked participants to estimate the distribution of reasons for a hypothetical 100 IMEs obtained by their organizations. Using this approach, the highest rates of use are to assess impairment and to analyze causation for occupational diseases and psychiatric disorders. IMEs are used moderately often to assess delayed functional recovery and extended treatment, and to evaluate medical necessity in some cases. IMEs are used with low frequency to assess physical restrictions or to evaluate causation for occupational injuries.

Reasons generally viewed as unacceptable for obtaining IMEs included "adjudicating the claim," unless information was simply unavailable through any other channel; case overload; lack of skill in obtaining information on the part of the adjuster; or to avoid contacting the attending physician.

Admissibility

Many respondents obtain IMEs in the belief that IME reports will serve as evidence in a dispute or proceeding. Actual ability to do this depends on the rules of evidence in the jurisdiction in question. In many jurisdictions, including Washington, the reports are considered hearsay. They are not evidence, preponderant or otherwise, unless they are introduced as a work product of a testifying examiner, or unless both parties to a dispute waive the rule. For example, the California Code (8:10727) notes that the Workers'

Compensation Appeals Board favors cross examination of medical witnesses by deposition.

Several benchmarking participants also noted that in most states, the IME report itself is not admissible in court. Similarly, there is a belief that peer review or file review will not hold up in court. The admissible evidence is the testimony of the evaluating physician. Many physicians do not want to testify, because of the many hassles involved. If willingness to testify is important, one must carefully select the evaluator to use.

Examiner Qualifications

Qualifications

There is general agreement in the literature about desired qualifications for independent medical examiners. These **qualifications** encompass several areas of **knowledge, expertise and skill**. Though a number of these areas appear to be self-evident, they are explained below because they comprise the necessary skill set to perform an excellent and fully defensible examination. Additionally, these areas have been observed as deficiencies in many audits of examinations. They are described below at the level of basic skills rather than certifications or specialization so that they can be used in training, and can be more fully assessed in future screening, testing, and credentialing of examiners.

Examiners should be **trained and knowledgeable about the body systems and health problems that the injured worker appears to have**. For example, if the worker complains of low back pain, the examiner should be knowledgeable about the anatomy and physiology of the musculoskeletal and nervous systems, and diagnosis of disorders of the low back. Knowledge about diagnosis includes knowledge about the evidence for the specificity and sensitivity of various signs, symptoms and diagnostic maneuvers. This area includes awareness of the correct method of performing diagnostic maneuvers. In other words, the examiner should know how to elicit and interpret key symptoms and signs. Board certification certainly improves the chances that the examiner will have these skills, but does not guarantee it.

There are circumstances in which examiners in the workers' compensation system should have **specialized abilities**. For example, if causation is an issue, the examiner should be able to conduct an assessment of work and home exposure to ergonomic factors, chemicals, and other sources of work-related health problems. He or she should also have a thorough knowledge of the evidence linking exposures and adverse health effects if asked to assess health issues other than evident direct trauma. Other circumstances

include those conditions that are rare or involve multiple-exposures.

Communication, interpersonal and language skills are crucial elements of the independent medical examination skill set. Because the results of an IME may affect the ability to obtain financially desired or needed benefits, it can be a threatening experience to the examinee. Further, not all examinees are excellent historians without careful questioning and interpretation. One of the main complaints about independent medical examiners is failure to listen or to cover points that are important to the examinee.

The examiner should be **cognizant of the evidence** supporting effective and efficient therapies and self-care of all kinds, whether physical, pharmacological, or surgical. The examiner should also be aware of the lack of evidence, or negative evidence, for many commonly used tests and treatments. Even effective treatments lose their effectiveness for an individual after a period of time, or may have negative effects if prolonged too long. Pharmacological therapy and physical medicine in particular fall into this category.

A **balanced health care perspective** is important as well for several reasons. First, placing precedence on medical or surgical therapy rather than other forms of therapy may prevent the examiner from considering the best treatment for the patient's circumstances. Second, many of the factors that delay functional recovery and return to work are not purely physical.

Examiners **rating permanent impairment** must be familiar with the use of the often complex rating systems deployed in their particular jurisdiction. In Washington, this would include the Washington system for spinal complaints and the AMA *Guides to the Evaluation of Permanent Impairment,* Fourth and Fifth Editions.

The examiner must be skilled in **applying medical logic** to the data acquired in order to validate the diagnosis, suggest specific additional testing, affirm or recommend changes in treatment, and to reach reasonable conclusions about causation, impairment, and

ability to work. Without this skill, and the ability to convey the steps in the analysis to the reader, the value of the data acquired will be largely unrealized. Knowledge and skill in answering the types of questions typically posed to independent medical examiners is also essential.

An excellent examiner will **maintain a neutral point of view** as a medical expert. The examiner will render opinions consistent with the case and the evidence for causation, test and treatment effectiveness, and the reproducibility of impairment assessment. He or she will not issue "boilerplate" reports (that are generic rather than specific in nature), nor use a preconceived framework based on a pro-business or pro-labor philosophy rather than the objective facts of each case.

The examiner should be able to render an opinion that is "impartial, unbiased, and objective." The examiner should also clearly **differentiate between facts and opinions**. The examiner can conceivably be the primary treating physician if able to momentarily suspend his or her role as patient-advocate, put in abeyance the physician-patient relationship and be skilled in providing the data and analysis needed. Generally, however, it is considered difficult for treating physicians to achieve this level of objectivity, especially in circumstances where some sort of dispute concerning their patient is involved.

In many jurisdictions, independent medical reports are not in themselves admissible in legal disputes. Therefore, another important skill of medical examiners is the **ability to testify clearly, logically, and in an informed way** in a deposition or hearing on the issues and facts in the case. When testifying, the examiner should be able to assimilate contradictory information and consider it reasonably, even if it changes his or her prior opinion.

One indication of **training and skill is Board Certification** in the area of inquiry. Another is Board Certification in Independent Medical Examination by the American

Board of Independent Medical Examiners. While these certifications represent assurance of competence in the two key areas discussed above, they may not be specific enough as a quality control mechanism.

Several states have regulatory qualifications for medical experts. In New Jersey, for example, a medical expert is one who performs twenty-five or more workers compensation exams per year. (*Administrative Code 2:235-5.10 Conduct of formal hearings:* (4)(m)(1)).

List of Eligible Examiners

California, Colorado, Nebraska, New York, and Washington require that all examiners be drawn from a list of qualified examiners maintained by the state. A few states require the judge/referee to pick from a list maintained by another impartial entity. For example, Illinois provides that a physician selected by the Illinois State Medical Society will perform a board-ordered IME. New Mexico judges are supposed to select from an authorized list compiled by an advisory committee. Minnesota provides for judges to select IME physicians from a list of "neutral doctors" to be maintained by the department, but since no such list exists, they work without it.

Credentialing

Washington, California, Colorado and more recently New York, credential examiners and place them on a state-approved list. The selection processes vary in their rigor. L&I requires each examiner to have some direct patient care and board certification in their area of medical specialty. The Executive Director of the Industrial Medical Council in California believes that the IMC selection process has improved the quality of IMEs.

Networks usually credential members. However, at present credentialing typically only includes checking for licensure, an absence of felony convictions, and perhaps

community reputation. Several respondents suggested adding a review of past reports produced by the examiner. This is done in at least one west coast network, with positive results.

The literature does not, in fact, support the assertion that conventional credentialing correlates with competence. Checking for malpractice claim losses, felony convictions and graduation from medical school simply assures honesty, ethical behavior and clinical training at a basic level.

Certification

Certification is a term that can be abused. Some use it to mean merely that someone has successfully filled out an application. In order for the term to be meaningful, it should be reserved for a process that requires evidence and then verifies that an applicant has special training or has demonstrated competency in the topic area under consideration. Colorado and Texas require training and certification testing for examiners in disputed cases. Only Required Medical Examiners must be certified in Texas currently, although a new law will require that all examiners be certified in the future. The literature recommends certification in mastery of the knowledge and skills for conducting IMEs and IME report writing.

Training

Training of evaluators is nearly unanimously accepted as a best practice by the benchmarking interviewees. While no proprietary networks require training, some offer it. Training of impairment raters is required in Colorado and Texas. In Colorado, training includes review of state practice guidelines. In Nevada, training on the American College of Occupational and Environmental Medicine (ACOEM) guidelines is required. California and Washington require training of chiropractic examiners.

Attending Physicians as Impairment Evaluators

In almost all jurisdictions, attending physicians can and generally do rate most permanent impairments, either numerically or by using terms that translate to a quantitative rating framework (primarily in Washington and California). After the physician's rating is received, a disability evaluator uses additional factors to develop the final disability rating. Several studies in California and Texas have shown that impairment examinations done by attending physicians were more variable and harder for the disability evaluators to rate than those done by trained examiners. This may imply that attending physicians need training or that they are less able to evaluate impairment. One should note that Disability Evaluation Unit raters, rather than physicians, did the audits cited in these reports. They may therefore reflect a legalistic or administrative view more than a medical technical one. The legalistic view may be the most appropriate in these instances.

Sources of IMEs

Recruitment of Examiners

There is an apparent shortage of qualified examiners relative to the demand for IMEs, particularly in high use states such as Washington. This manifests itself either in longer scheduling times for the IMEs or the lowering of credentialing standards. Peter Barth noted in a 1985 study, "… there is one universal problem – a factor that affects recruitment in every panel and IME state. Most doctors do not want to testify." Comments made during our initial interviews suggest that these conditions have not changed appreciably. To reduce turnover and increase recruitment of examiners, some studies suggest active nomination or recruitment of physicians by other physicians. One recommended practice is nomination by a medical school or medical society. Some experts are only willing to serve occasionally; recruitment realities should be acknowledged.

To aid in the recruitment of competent doctors as examiners, Peter Barth suggested the following changes in evidentiary rules:

- Accept the medical report as evidence
- Use depositions rather than testimony at trial
- Scrupulously keep to schedules for hearing dates
- Allow one doctor to testify for all on a panel

Networks

According to the literature, consistent use of a smaller number of examiners from a standing list means the examiners gain in expertise and the ability to deliver pertinent material efficiently to adjudicators, and thus can gain credibility. Benchmarking

participants think the best practice is to use a manageable, small, carefully selected IME network if availability and timeliness can be assured. They prefer that evaluators be Board-Certified. They screen out examiners who display obvious bias towards either side. The network includes key specialties and formal review of the work product is used to ascertain quality.

Several published sources suggest that use of a large number of examiners on an ad-hoc basis eases recruitment and encourages diversity and "evolution in methodology." Use of less experienced doctors may reduce their ability to deliver pertinent and correct information to adjudicators, but may increase the perception of lack of bias.

Use of IME Brokers

There are no published objective studies of the advantages and disadvantages of the use of IME brokers, commonly referred to as "panel companies" in Washington. What are published are advocacy pieces.

Benchmarking participants are divided in their opinion of IME brokers, or "panel companies" (the term is in general use only in Washington). Third Party Administrators and some employers in Washington find them useful. Respondents in other states had a very negative opinion of these firms. Rates of use nationally range from under 5% to 80%.

Positive Attributes

The primary favorable responses regarding IME brokers have to do with logistics. Participants of this opinion feel that the administrative functions provided by IME brokers improve the timeliness of report return. Brokers also handle recruitment of examining physicians and scheduling of exams in some cases. They perform some quality assurance, although it appears to be limited to proof reading for spelling, grammar

and format in many cases. In essence, the IME brokers are felt to be useful because they provide administrative services generally otherwise performed by payers.

Some participants feel that using an IME broker conferred credibility in judicial proceedings. This perception may exist because IME brokers in Washington must apply to the Department of Labor and Industries to provide their services. This is not the case elsewhere.

These participants feel that they have developed close relationships with the staff at the broker companies. They can then discuss customer service and requests. They also are able to specify when not to use certain physicians.

Negative Attributes

Participants from national carriers cite a number of negative responses about IME brokers. They felt that there is wide and unpredictable variation in the quality of reports received. Some are "good" and some are "awful." They also note that the companies reduce fees paid to physicians, presumably reducing the quality of the evaluation. For these and other reasons, several respondents, including attorneys, believe that these reports are not credible in court. Some respondents also feel that the use of non-medical offices for conducting the examinations creates problems.

IME Requests

Ordering IMEs

In all instances, participants reported adjusters are the ones who actually order IMEs, as they are the overall managers of the claim. The preferred best practice, however, is to have a nurse or medical director frame or review the questions posed in the request for the IME. Some organizations consistently use nurses or medical directors in this capacity, most stated a preference for this approach, other factors being equal.

In states in which dispute resolution occurs primarily in the judicial system, judges can order IMEs to assemble factual information. Plaintiff attorneys may order IMEs in many jurisdictions. Adjusters typically order defense IMEs, although the initial request may come from defense counsel.

Questions

The best IME requests include questions customized to the specific issues or problems that are unclear or in dispute. Several participants mentioned that low adjuster turnover, and therefore greater experience with asking focused questions, results in better questions and summaries. As noted previously, using knowledgeable nurses or physicians to pose or review the questions assures that they are asking for very specific answers in areas where medical logic and the available data cannot yield a clear answer. Some requestors use standard letters for certain types of problems such as hearing loss. It is not clear that this practice leads to optimal results.

Participants strongly recommend that the requestor include a detailed narrative summary of the case to date. While there is some concern that omitting information from the summary might misdirect the evaluator, this did not seem to be a major issue, assuming the summaries were thorough.

Choice of Examiner

The ideal selection method assures that the examiner fits the needs of the evaluation. Different parties have different views of the need. Medical articles emphasize the need for medical expertise and knowledge of IME methodology and report writing skills. Advice from attorneys involved in litigation emphasizes the need to pick an examiner who will testify well (knows pertinent laws of the jurisdiction, can make appropriate medico-legal distinctions, whose medical credentials are impeccable) and whose track record is established (testimony is predictable) (Pierce 1998). Worker-oriented materials emphasize the desirability of using treating physicians who owe their first duty to the patient rather than to the insurer or employer. They also disparage physician-examiners whose practices are largely confined to IMEs and providing legal testimony, or who regularly testify on behalf of insurers and employers. Employer-oriented materials emphasize the need to participate actively in the examiner selection process.

Comment: Get this citation, or drop the comment.

Several methods of selecting examiners in disputed cases were specifically recommended against in the Barth study. These included appointment by the governor (increases odds that political factors will dominate over professional or scientific ones) or selection by court referees (referees will choose familiar panelists, and those who work well in "the system" rather than necessarily those who are most expert or objective). Barth notes, "In principle the idea of allowing any of the parties in a dispute to influence the makeup of the panel is at odds with the basic pre-condition of panel objectivity." His proposed solution was to have a referee other than the one who will hear the case choose the examiner. Another suggested method was to choose doctors from lists submitted by state medical associations or medical school faculties.

In California, selection of examiners for unrepresented workers involves generation of a random list of three Qualified Medical Examiners from the appropriate specialty. The

injured worker then chooses from this "panel." Florida and Texas require that the same examiner also provide subsequent IMEs in the case.

The prevalent practice at this time is that the selection of the specific evaluator is at the discretion of the adjuster. Criteria used, generally informal, include Board credibility, which in turn relates to the issue at hand. Selection of evaluators is almost never a formal process.

Specialty of Examiner

The consensus in the literature is that examiners should be selected from the specialty with medical expertise in the area of inquiry, whether a case is disputed or not.

Number of Examiners

Benchmarking participants express a strong preference for a single examiner. In cases where the examiner may be biased towards further surgery, there is some sentiment that a combination of a surgeon and a non-surgeon might be useful. In other cases, multiple examiners might be useful if there were true multi-disciplinary issues, for example a case with both musculoskeletal and behavioral components. Participants feel that in their experience, these cases are unusual rather than the norm. In our review of Washington IMEs, two physician panels with an orthopedist and neurologist combination were the most common type. There is no published evidence that quality is significantly enhanced with the examination by the second examiner.

Provision of Records for Review

Best practice is for all pertinent and available prior medical records to accompany the request, arranged in chronological order, with duplicates removed. It is most useful to separate the records by type, i.e. clinic records, imaging reports, operative reports, and so

on. Careful selection, duplication, assembly and preparation of the file before the appointment is key so that the examiner does not waste time fumbling through paper, and can efficiently develop a solid understanding of the background and facts in the case as a basis for opinion.

The examiner's ability to formulate a fresh opinion is reduced if he/she must rely on others' interpretations of the primary data. For example, when the IME has been ordered to clarify diagnosis or evaluate adequacy of treatment, certain primary source documents are key: all test results, surgical notes, and films. Likewise, if the IME is to consider causality, details of the accident from the employer's or insurer's injury investigation along with medical records from the initial medical visit and acute injury care period provide the best historical source of "clues" as to causality.

Examination Process

Scheduling

The best practice in this area is to call the examining physician's office to secure a commitment to conduct the exam, and then have the office contact the examinee to agree on a time for the evaluation. Flexible contact by a health professional's office, rather than a "summons to appear" that arrives in the mail, is felt to be more respectful and less prone to cause apprehension and conflict. After the time slot has been secured, the requestor should send all pertinent medical information as described above.

The Washington scheduling practice is to issue a unilateral "summons to appear" for the examination. This method of scheduling may significantly inconvenience the examinee, and reinforces the appearance of the examination as part of an adversarial proceeding. Inconvenience increases the "no-show rate" and leads to increased expense and delay. The adversarial tone interferes with the ability of the examiner to elicit a complete history and perform an accurate examination. A number of authorities have suggested an alternative that respects all parties and preserves neutrality. They suggest arranging a mutually agreeable time instead of only issuing a "summons to appear."

Travel Distance

Ensuring a reasonable travel distance is an important dimension of access to care. The term "reasonable" should reflect the examinee's ability to travel given his or her medical condition. This again respects the examinee. It may be difficult given the lack of qualified and neutral examiners in some areas. References in statutes are usually to one-way distances. In Minnesota, reasonable is defined as 150 miles (*Statutes Sec. 176.155 Examinations:* Subdivision 1 – Employer's Physician). In Wisconsin, it is 100 miles (Wisconsin Statutes 102.13(4)). In Texas, it is 75 miles (Regulations 28 TAC Sec. 126.6 Order for Required Medical Examinations). New Hampshire sets it at 50 miles. In Utah,

New Jersey, and most other states, acceptable travel distance is defined as "reasonable."

Material Provision and Preparation

A very important logistical consideration is obtaining and providing to the examiner past medical records, pain inventories, pain scales, and job and occupational history questionnaires. These should be complete, and provided unduplicated and in chronological order. Several sources emphasize the need for complete information to be provided to the examiner. For example, in a Hawaiian court proceeding, the court wrote: "Where the opinion expressed in an independent medical exam is based upon an incomplete review of existing health care records . . . it generally tends to raise as many questions as it answers. [Such] opinions are only as good as the information upon which they are based and the qualifications of the examiner to interpret that information." (Hawaii, 1994)

Examinee Identification

The best practice is to obtain positive identification from the examinee when he or she presents for the IME. Identification containing a photograph of the examinee is preferred, such as a driver's license. The form of identification and any identifying numbers should be recorded in the report.

Declarations / information

At the beginning of the examination, the examiner should clearly establish his or her identity and explain the purpose and logistics of the examination. The explanation includes the purpose, nature and scope of the examination. The examiner should inform the examinee that he or she has no relationship with the current attending (treating) physician. He or she should also inform the examinee that the nature of the IME precludes establishing a doctor-patient relationship or doctor-patient privilege, and that

the examiner will not provide treatment to the injured worker as part of the examination or subsequent to it, except where specifically permitted by state statute or regulation.

The examiner should tell the examinee that the examination is not intended to be uncomfortable, and ask to be informed immediately if a maneuver is uncomfortable. The examiner should obtain specific consent for the examination, as well as authorization to release the report, if required in that state. All of the above should be documented in the IME report.

Fees

There was agreement among benchmarking participants that all or most of the fee paid for an IME should go to the evaluating physician. There was some disagreement about the actual amount that should be paid. Several felt that the best practice is to obtain a discount from the prevailing fee schedule. Others felt that these discounts were a disincentive to obtaining a thorough evaluation. Some pay more for priority scheduling. This seems to depend on the needs of the case.

A fundamental issue in comparing L&I to best practices is that L&I is the only organization we could find that effectively outsources such a significant portion of the IME process. There are nine separate components that need to be accounted for in considering relative fee bases, costs and best practices to L&I as an organization. The administrative components include: case analysis, scheduling, examiner recruiting, credentialing and training, organizing medical records, and quality management processes. The medical management component conducted by the physician includes the records review, the examination itself, and report preparation and editing.

We did not locate any published studies of fee allocation, overhead, or relative IME fee schedules.

Evaluation Content

There is a fairly uniform, sequenced process for the conduct of an examination summarized in the texts and articles reviewed. Published information about independent medical examinations is largely written by and intended for physicians who act as examiners. It appears in peer reviewed texts and a limited number of review articles. In addition, the American Board of Independent Medical Examiners, the American Academy of Disability Evaluating Physicians, and the California Industrial Medical Commission have published lists of the items that should be present in an independent medical evaluation. There is a clear convergence among the recommendations in these sources. We have presented a summary here rather than citing individual elements to a particular reference, as the concepts and data elements were similar.

We did not find statutory or regulatory requirements for the process or content of independent medical examinations themselves.

Records Review

Published sources recommend reviewing past records of office visits, test results, physical medicine notes, surgical procedures, and scales and inventories in chronological order. It is important that the examiner have all pertinent records, and that they be well arranged and easy to review. The examiner should review primary records, and not rely exclusively on summaries prepared by others.

There are two views about when to do this records review. The predominant view is that it is preferable to review the materials prior to the examination in order to identify areas that require clarification during the history and to allow the examiner to focus particular attention on key areas during the physical examination. Alternatively, the examiner can review the materials after the examinee leaves to avoid creating any preconceptions during the history. The danger with this approach is that there will be no opportunity to

clarify issues and inconsistencies directly with the examinee.

The examiner should also review past test reports, and primary output such as radiographs or EMG readings and nerve conduction velocity studies. Relevant tests in workers' compensation might include plain radiographs, other imaging studies, electrophysiologic tests, laboratory tests, symptom inventories, functional capacity evaluations, and neuropsychological testing. The reviewer should note any questions he or she might have, as well as inconsistencies among tests or between test interpretations and the history and physical examination.

The output of this review should be a listing of the records reviewed, by source and date, a synopsis of the mechanism of injury, symptoms and signs as they progress, a summary of diagnoses, treatment to date, and progress towards functional recovery. It is very important to include cogent analytic comments about the accuracy of diagnosis and reasonableness of testing and treatment (see Analysis Section, page 48). A simple review without such comments, even if clear and inclusive, is of questionable value for a non-medical audience.

Examiner Communication

The available literature recommends that the examiner establish rapport with the examinee to ensure that he or she obtains a complete and accurate history of exposures, the injury or illness, related issues, and factors that could affect functional recovery. Published sources also suggest that the examiner listen carefully, respectfully and objectively to the examinee. They recommend that the examiner paraphrase the history back to the examinee to ensure that their understanding is correct.

Histories

One effective starting point in obtaining a complete history is to have the examinee fill out a structured questionnaire before the examination, and then review it with the examinee. A number of different histories may be involved.

The Medical and Employment History

The first task in taking a history for an independent medical examination is to identify the examinee's current primary concern, as well as any other issues of concern. These issues may or may not include the chief complaint, which should also be elicited.

The examiner should then explore the examinee's pre-injury status, including pre-existing conditions, previous injuries, and the examinee's perceived pre-injury functional status (the effects of pre-existing or previous injuries or conditions, which may be asymptomatic). The examinee's work absence history prior to the current health problem should also be explored.

Job and Occupational History

Particularly when the issue in question is causality, the examiner should review the examinee's occupational history for all jobs prior to the current complaint. The review should include work tasks, exposures, and protection such as engineering controls, personal protective equipment, and ergonomic practices. Non-occupational exposures should be sought as well. It is often helpful to review mutually-derived job descriptions agreed to by the worker and the supervisor, view videotapes of actual job tasks, review ergonomic evaluations of the worker's work station or review and summarize exposure monitoring data to quantify exposure.

In cases where there is a delay in returning to work, or persistent complaints out of proportion to the apparent illness or injury, the examiner should explore the examinee's task and job satisfaction, as well as work relationships with co-workers and supervisors.

History of Present Illness

The examiner should elicit the mechanism of injury or illness with some specifics such as force, load, dose of exposure, and so on. It is also helpful, particularly in cases of delayed return to work, to explore the worker's perceptions about the causation of the health problem and fault for the causative factor.

After ascertaining the mechanism of injury, the examiner should obtain the examinee's recollection of the symptoms at the time of the injury or illness, as well as their progression to date. This line of questioning culminates with the worker's current symptoms and functional limitations.

Part of the history to be assembled and assessed is the treatment history and response to treatment, particularly if the questions posed relate to treatment effectiveness or recommendations. Other key elements are the worker's disability history; functional and physician-imposed work restrictions; and effects on social function. The disability history reflects a combination of treatment effectiveness, health beliefs and psychosocial factors. A good summary measure of the effectiveness of care and the interpersonal skills of the attending physician is the patient's satisfaction with the care delivered.

Pain and Symptom Inventories

In our literature review, medical experts emphasize the need to uncover psychological and behavioral components of an illness or injury episode, because they believe that these problems must be acknowledged and addressed in order to facilitate functional recovery and return to work. Employer and insurer materials are silent in this arena, presumably out of concern for possible complications of claim management. Many jurisdictions no longer allow an assessment of pain to enter into rating systems, because of its susceptibility to distortion by vested interests.

Symptom inventories and drawings can provide a semi-quantitative measurement that can

be scored against population norms. They are often useful to provide another view on the patient's level of symptoms and his or her *perceived* impairment. Pain scales, maps and descriptions are also useful as direct sources of pain levels, locations, character and frequency for states such as California that rate impairment caused by pain. Such instruments include pain drawings, analog pain scales, and pain inventories. Personality inventories may be useful to understand some symptoms, symptom intensity and chronicity, or absence from work. Depression scales are an effective way to identify and quantify depression that may be causing delayed return to work, or may be a result of a loss of function or work status. When using inventories and scales, it is important to ensure accurate grading and interpretation.

Special Detailed History for Cases with Severe Pain Complaints in Excess of Objective Findings

A focused history for circumstances that predispose patients to symptom magnification or the development of chronic pain syndromes may prove useful in guiding effective future treatment. Situations calling for a focused history include cases where symptoms are impeding functional recovery, when there are questions of symptom magnification, or when one issue raised is the need for future treatment or vocational rehabilitation. We should note that a number of jurisdictions, including Washington, do not rate impairments attributed to pain. This discussion is directed at clarifying symptom drivers, maximal medical improvement, and appropriate therapy.

Physical Examination

Following collection of historical data that supports the focused inquiry called for by the examination request (and which generally includes only a selection of the information discussed above), the examiner should carefully perform a similarly focused physical examination, taking care not to cause discomfort. The examiner should note whenever a

maneuver is terminated because of complaints of pain or discomfort.

The examination should focus on the area of injury, including related areas (for example, the cervical spine in some upper extremity neurological complaints, or the contralateral side in cases involving atrophy, deformity or joint motion). The examination should be complete but relevant. As a general assessment, the examiner should note habitus, gait, station, appearance, and affect, as well as the presence of assistive devices, stimulators, braces, and so on.

The report should include relevant measurements, bilaterally if possible. It should include all pertinent positives and negatives, as well as the examinee's response to the examination and non-physiologic findings such as Waddell's signs. Any symptom magnification should be noted. More specifics on the examination of various body areas can be found in the ACOEM *Occupational Medicine Practice Guidelines*, the AMA *Guides to the Evaluation of Permanent Impairment*, and medical texts.

Ensuring Accuracy and Acceptance of the History and Physical

Several published sources suggest that the examiner dictate the record review, history and examination portions of the report in the presence of the examinee to ensure agreement with the history and physical findings. Of course, the examiner will have to weigh the examinee's credibility as a historian and may need to be more actively involved in resolving discrepancies between the examinee's recollections and those reflected in the record.

Analysis

Careful analysis of the past history, the history of the present illness or injury, the work history, test results and the physical examination as a group of data should yield answers to the questions posed, or reveal the need for further consultation or testing.

An important piece of data in interpreting the history obtained from the examinee is the examiner's assessment of his or her reliability and consistency as a historian. This should be noted affirmatively or negatively. Cooperativeness, or lack thereof, with the examination should also be noted.

Diagnosis

The examiner should analyze past exposure records, job descriptions, and records from all treaters and testers in chronological order to revisit the diagnostic logic if diagnosis is one of the issues asked for in the examination. He or she should note and explain agreement or disagreement with the diagnostic logic and the diagnosis.

Causation

The examiner should analyze past exposure records, job descriptions, and records from all treaters and testers in chronological order to revisit their causality logic if causality determination is one of the issues asked for in the examination. He or she should note and explain agreement or disagreement with the causation logic and statement of work-relatedness.

The examiner should describe the logic, methods and rationale for his or her own causality conclusions as well. If there is evidence in the literature to support causality, other than obvious trauma, it should be cited. If the examiner differs from prior evaluators about the attribution of the illness or injury to work, he or she should detail the

points of agreement and disagreement, including epidemiologic data for association with work, and any reputable consensus panel findings, for example Centers for Disease Control or NIOSH panel proceedings.

Prior Testing

The examiner should analyze past records from all treaters and testers in chronological order for the timing, appropriateness and findings of tests. The examiner should analyze the interpretation of past test results, if qualified to do so. Again, these are subject to misinterpretation at times. There are studies of test interpretation accuracy in various practice guidelines, but none directly related to IMEs.

Treatment Appropriateness

The evaluator should comment quantitatively, and with reference to the evidence base, on treatment timing, duration, appropriateness and effectiveness. He or she should cite differences between what occurred and best practices.

Activity Modification

The evaluator should comment quantitatively, and with reference to the evidence base, on the appropriateness of work restrictions or accommodations, and the timing of return to work. He or she should cite differences between what occurred and best practices, with reasons for the difference.

Maximal Medical Improvement

The examiner should explain the logic and rationale used to conclude whether or not the worker has reached maximal medical improvement or whether further functional recovery can be reasonably expected.

Impairment and Rating

Examiners should validate previous impairment ratings. These are often incorrectly calculated.

In supporting current impairment ratings, the rater should describe the method used to determine the rating, and describe the logic and rationale for the rating reached. He or she should also describe the relevant capacity for social and work functioning as it relates to the degree of physical impairment.

Future Medical Care

Based on the claimant's history of exacerbations, current condition, and the known natural history of the illness or injury, the examiner should forecast the need for future testing and treatment as specifically as possible.

Recommendations

The consensus view in the literature is that examiners should make recommendations in response to questions posed by, or implied by, the examination request. Recommendations should be based on the available evidence, or if lacking evidence, consensus views of what is effective, with benefits outweighing risks. Such recommendations could include the need for further testing to define the condition in question, either to further the analysis of causation, or to clarify the diagnosis. Recommendations may also be called for regarding further treatment, the prognosis for further improvement, physical or mental impairment, the examinee's current or future work capacity, the need for vocational rehabilitation, and the potential for employment.

Quality Management

The definitions of quality in IMEs reflect the purposes previously outlined. In essence, a quality IME is "impartial, unbiased, objective." Commonly used definitions further incorporate the concept that a high-quality IME meets the needs of the customer (requestor) by answering the questions posed in a manner that is understandable to a non-medical person. To do so, the report should clearly outline the steps taken in the evaluation. It should be well organized, and complete but to the point. The length and structure of a high-quality report varies by case. No studies have concluded that formal guidance on format or structure alone is of value.

The published literature on management of IME quality is limited to check sheets for audits of examination reports. Brigham implies that reports should be reviewed against criteria for completeness and feedback given to examining physicians to improve the quality of the reports over time.

The best practice in quality control is rigorous medical and legal review of a random sample of IMEs with specific feedback to evaluators. A remediation plan is prepared and agreed upon if recurrent issues are noted. Responding to examinee complaints, while very important, is viewed as addressing only a small subset of potential issues, primarily examinee satisfaction, so other quality mechanisms are employed in addition.

The Industrial Medical Council in California currently performs annual random audits of impairment evaluations, in addition to audits of all disputed evaluations. The sample for the former is relatively small. Auditors use a formal tool that tests for ratability. Auditors are raters, not doctors or nurses, although health professionals on the IMC staff may become involved in the evaluation of examinations that are the subject of complaints.

Several organizations do refuse payment if an IME is of poor quality. In the case where

the report is of poor quality but has been sent to opposing counsel directly from the examiner, or is otherwise considered to be evidence, another report is ordered. The usual practice is to ask for addenda to clarify points that are unclear or insufficiently explained. It is not clear what is to be done if the analysis is incorrect or the impairment rating is incorrect. It is prudent to track these not uncommon occurrences and refrain from using the involved examiner again.

The typical means of quality management presently is a review of the report by the adjuster who requested it. The reviewer typically checks to see if the report

1. Answers the questions asked
2. Addresses all issues raised
3. Uses appropriate language – is it readable?
4. Is a predictable response, based on the recognized bias of a particular examiner.

Benchmarking participants would prefer nurse or physician review to address the medical correctness of the report as well as the *prima facie* issues listed above.

Several state agencies have studied the completeness and ratability of IMEs done by qualified examiners and by attending (treating) physicians. They have also studied the effects of legislative and regulatory changes on the cost, frequency and intensity of medico-legal examinations in their state. One agency compared the rating percentage among attending physician reports, insurer-selected examiners and other examiners. The effectiveness of independent medical examination reports of varying completeness, accuracy and approach in dispute resolution has not been studied and reported.

Billing accuracy is another aspect of quality. Several respondents mentioned problems with incorrect use of codes, particularly by attending physicians, who are not providing IMEs. Others noted that up-coding is not uncommon.

There are some references in the literature to variation in the quality of IMEs. Most of

the studies done have involved comparisons of impairment ratings. Barth (1985), Greenwood (1985), and Chibnall, Tait and Myers (2000) all noted that impairment ratings were variable, based in part on non-objective factors, and more variable as the degree of rated impairment increased. Both the Chibnall study and several studies in Texas (Campbell and Russell, 2000; TWCC/ROC, 1996) further noted that raters affiliated with employers or insurers tended to rate lower and vary from other ratings of the same worker. Studies of attending physician ratings in California and Texas found that AP reports were less reliable for rating or more variant than those of credentialed examiners (UC Data, 1997; Adams, 1999). These differences were attributed to a lack of training and experience, rather than bias on the part of the attending physician.

The California Industrial Medical Commission (IMC) conducts annual reviews of 1000 Qualified Medical Examiner (QME) reports per year as part of its mandate to assure the quality of QME reports. About 5-10% of the reports selected are those about which there have been complaints to the IMC. The remaining reports are selected randomly. The review is done by non-medical "raters" against a set of process and content criteria developed by the IMC. Individual case feedback is given to examining physicians. The results are published in the aggregate by the IMC.

Satisfaction

Several published authorities mentioned surveying clients (examinees) periodically. This is the preferred approach, although no one has elaborated on the content of such a survey or created norms for one.

Some inferences can be drawn from these studies and from recent studies of worker satisfaction with workers' compensation in general.[1] The best practice is the use of questionnaires continuously over time, administered by a disinterested party to a random or stratified sample of examinees. Topics that could profitably be surveyed include explanation of the need and form of the examination, scheduling, access to the examination site, courteousness and appropriate conduct of non-physician staff, examiner conduct and interpersonal behaviors, familiarity with the history of the problem, recollection of elements of the history and examination for thoroughness, opinions of thoroughness, and overall satisfaction with the process.

IME brokers report that they perform quality assurance on their work product. This takes two forms – (1) exit surveys of examinees, and (2) review of reports for spelling, grammar and punctuation; compliance with formatting; completeness; responsiveness to client questions; and in one case, medical logic and *prima facie* accuracy. This process is not published. The process and the results are referred to in marketing literature only.

We would also infer that periodic surveys of attending physicians about the usefulness of the information in the IME, and the effect of the evaluation on the relationship with the claimant would be quite useful. One reason for obtaining an IME is to get expert feedback on past diagnoses, testing, treatment, and disability management. The value of the examination is leveraged if the attending physician learns something useful from it.

[1] Texas studies, URAC pilot

Barth concluded, "The clearest single finding that has emerged in the course of this study is that satisfaction with panels is invariably related to the perceived skill and objectivity of panelists. . . . [Though] structure and procedure are important, the critical element in an effective panel program is the doctors. They must be able to earn the confidence of all parties involved in the system. To do that, they must demonstrate both skill and objectivity." This observation supports the need for data that could be used to improve the quality and credibility of IMEs. Written, comparative or scaled feedback to examiners and IME brokers should be sent out for information and comment to foster quality improvement,.

Satisfaction measurements of other parties in the process, including employers and IME examiners, are important to broader systemic quality improvement efforts. These should be incorporated in an on-going program of satisfaction measurement in which results are shared with all parties in the process of improving the quality of IMEs.

Outcomes

We asked participants in the comparison (best practices) study about the effectiveness of IMEs and about their most effective practices, but the answers were limited to opinions that high quality IMEs, obtained in the ways outlined in this report, would result in more effective resolution of the issues in question. (No respondent had any hard data linking IME characteristics to outcomes in any way whatsoever.) The caveat is that the existence of the high-quality IME data is only a first step.

The literature does not contain comparative studies of the effects of IME report data on the outcomes of testing, treatment, return to work, impairment compensation, or disputes.

This series of studies did not include a direct examination of the use of the information in IMEs, or the effect of the information on outcomes such as determining appropriate causation of reported illnesses or injuries, securing more appropriate medical care or work placement, or the decisions in dispute.